Social and Rehabilitation Service UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Volume 1/Number 8/February 1973
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HUMAN NEEDS

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Cover Notes

In the frantic chaos of our busy transportation centers, faces tell the story. Deep lines etched indelibly on a haggard countenance; the fleeting look of desperation crossing a young woman's face; drawn expressions caused by hunger and fatigue. And all around, the icy presence of a cold, indifferent crowd.

Through the pulsating whirl of America-on-the-move, the human condition stands starkly in relief. It can be felt in the tense, electric atmosphere of a reeling Midwestern airport at early morning; heard in the frantic, almost violent disorder of a decaying East Coast railroad terminal at rush hour; seen in the nauseous glare of a Southwestern bus station at midnight.

In the hundreds of complexes where people begin—and end—their journeys, at any hour, on any day, there are countless men and women without money, hungry, exhausted, frightened, ill. They are people who need help.

Too often in our shifting, mobile, highly complex, and increasingly impersonal society, the plight of individuals away from home—or without homes—goes ignored. The returning GI facing an uncertain future; the alien arriving in America for the first time; the ex-convict searching for a new life; the young mother traveling alone with a desperately ill child; the elderly, the sick, the very young.

People-on-the-move very often are people in need of help. For many Americans, the TV-made image of apparently carefree men and women moving easily from airport gate to airplane lounge falls abysmally short of the reality. Critically urgent problems confront many of them as they move in an endless procession between our towns and cities. Many of us could ease their difficulties through greater awareness of their needs. — M.A.B.

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Milwaukee's public and private sectors join in an innovative program.

How industry can help the Alcoholic

BARBARA REYNOLDS. "I am beginning to live again. The days of just existing are slowly fading. Not completely, for I don't want it to happen that way. I want to always be able to compare the old days of darkness to these beautiful new days of light."

These are the words of a recovering alcoholic enrolled in a unique rehabilitation program which started last summer in the Milwaukee, Wisconsin, area. For this man, the old days of darkness brought with them the intermittent knowledge that he had joined the legends of the living dead. He could no longer control his mind—his brain seemed to function apart from his being. The self-confidence, euphoria, and reason he was accustomed to buying at the liquor store proved inferior to the mental energy he once had.

Liquor had turned on him, manifesting itself in rage, resentment, and indecisiveness. In time he lost everything—family, friends, and employment—everything but the insatiable thirst for alcohol.

The new days of light are the welcome result of an industry-oriented program sponsored by Milwaukee's DePaul Rehabilitation Hospital in cooperation with the Wisconsin Division of Vocational Rehabilitation (DVR). In the opinion of many experts, no better corridor of the Nation's alcoholic population could have been selected.

Ninety-seven percent of America's 9 million alcoholics are employed and of above-average income, erasing the Skid Row/bum mythology. Forty-five percent of all alcohol abusers are in managerial or professional categories; 25 percent are in white collar jobs (including clerical); and 30 percent hold factory or labor jobs.

Alcoholism is defined by the National Council on Alcoholism as a chronic and progressive illness characterized by excessive drinking of alcoholic beverages. It is considered a public health problem affecting the general welfare and economy of the country.

Alcoholics are described by the Council as excessive drinkers whose dependence on alcohol has reached the stage where there is a noticeable disturbance or interference with bodily and mental health, interpersonal relations, and social and economic functioning.

HEW views alcoholism as America's most "treatable untreated" disease, draining the economy of $15 billion a year. Small wonder, then, that industry was selected by the Government for the task of returning formerly productive workers to the sober world—before these men and women are consumed among statistics. (According to a recent HEW study, alcoholism is the Nation's fourth killer—just a step behind cardiovascular disease, cancer, and auto accidents.)

The Milwaukee program is built on a proven success formula. It employs on-the-job, early detection techniques together with back-up support from the families of recovering alcoholics. A model, designed by a private Milwaukee company and DePaul University, had a spectacular 95 percent recovery rate over a four-year period—proba-

bly the highest performance record of any internal personnel project in U.S. industry.

Another impressive project feature—the first of its kind in the Nation—is the DePaul Sertoma Simulated Workshop. This facility serves a two-fold purpose in the program: vocational evaluation counseling and on-the-job work adjustment in a controlled but familiar setting. It also provides paid employment for chronic alcoholics who are unsuitable for competitive work.

The first task, completed after the DVR received a three-year, $300,000 grant from HEW's National Institute of Mental Health in August 1972, was to lay the groundwork for gaining industrial cooperation in early detection. More than 63 companies in the Milwaukee metropolitan area joined in the project, according to Miss Jean Leland, Assistant Supervisor of the Milwaukee DVR.

Miss Leland says the following policies were established by the cooperating companies:

- alcoholism will be recognized as a disease rather than as a crime, thus opening the way for employees to receive regular hospitalization benefits while undergoing treatment
- alcoholism is a vital concern of the employer because it affects the employee's work performance, but social drinking is not a company's concern
- no employee's job security or position would be jeopardized by his acceptance of treatment at DePaul, nor would employees suspected of alcoholism be given special privileges not offered to those with other chronic illnesses, and
- standard company personnel procedures would not be altered because of the program.

According to Miss Leland, the most significant impact that companies made upon the program was their favorable response to participating in early detection. This marked a clear departure from the techniques of the past when alcoholics usually "hit bottom" before help came.

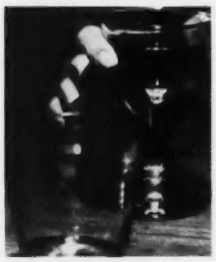
"Employers used to look for deterioration in work performance or attendance as a sign that an employee had a drinking problem. But it has been proven that it is the individual who is the first person to know that a drinking problem exists, even though he or she may deny it. The family usually learns next, but the employer is the *last* to know since the alcoholic tries to protect his job to preserve a link with respectability," she says.

"While the traditional approach to case-finding and referral in industry is effective, it cannot be regarded as *early* case-finding," Miss Leland points out. "A better approach is to develop 'internal resources' among family, friends, and fellow employees to generate external sources of referral. External resources leading to identification and referral can provide as much as a five-year head start on the road to recovery," she says.

Thus, Miss Leland pinpoints an alternative program which includes the following:

- development of an "industrial alcoholism" team to implement an action program to speed up the process of early case-finding and referral of suspected employees
- pre-diagnostic screening to formulate plans for treatment and rehabilitation methods tailored to the needs of the individual client
- provision of a full range of services to alcoholic clients, including inpatient treatment, outpatient treatment, work evaluation, work adjustment follow-up, and other supportive services after a return to employment, and
- close cooperation with employer, union representative, family members, clergymen, and others so that these individuals can lend appropriate support to each client and assist him in overcoming barriers to a lasting recovery.

Equally important to early case-finding and treatment is the very human touch added by industry—the assignment of an alcoholic representative from



the companies' staffs to work along with the industrial alcoholism team. Ideally, the representative should be a recovering alcoholic himself.

Trained at DePaul for 22 hours in the techniques of early identification and confrontation, the alcoholic representative's role is not that of informer or clinical diagnostician. Rather, the representative provides a sympathetic shoulder for the alcoholic to lean on between the time of his entry at DePaul to his recovery.

In further defining the key role of the alcoholic representative, Miss Leland says that "his basic responsibility is to arrange for admission to DePaul and to deal with family problems that may arise during treatment. He also checks up after treatment to be sure that the employee maintains sobriety and performs well on the job."

"The alcoholic representative," she adds, "may also inform the employee that his job will be protected, but only if he will actively seek help. He also is the first to confront the alcoholic and convinces him or her that treatment will be handled in a completely confidential manner."

Presently, the DVR-DePaul rehabilitation program has 57 clients. It is projected that 250 clients will receive services during the first year and that 200 of these will be rehabilitated. Miss Leland estimates that of the 250 clients, 160 will receive work adjustment in the Sertoma Workshop and 25 others will be given vocational training.

Once admitted to the rehabilitation program, most alcoholics are scheduled into a 30-day Phase I treatment plan, beginning with detoxification ("drying out").

"The detoxification technique is quite tedious," Miss Leland says. "Withdrawal from alcohol can be more dangerous than heroine withdrawal. If not handled properly, the patient can die from convulsions, cardiac arrest, or from a number of other physical reactions. Tranquilizers and vitamins are administered in some cases as part of the drying-out process," she adds.

Phase I, according to Miss Leland, marks the start of vocational and psychological testing. This is also when the family gets deeply involved. While undergoing treatment, the alcoholic attends more than 20 lectures covering all phases of alcoholism. He also becomes oriented to Alcoholics Anonymous (AA).

Ultimately, the patient will be encouraged to join the AA, whose members work closely with DePaul and other treatment centers, serving in many cases as one-to-one counsellors for alcoholics in the recovery process. Experience has proven that those who fail to join AA have little chance of a completely successful recovery.

Not so long ago, the project would have been a "mission impossible." However, there has been a recent shift of the winds in society. In the past, society labeled the problem drinker a "moral degenerate" or an unsalvageable social reject who was somehow inferior to the sober American. The change, fortunately, has lifted alcoholic rehabilitation into the realm of the possible.

"I also feel there has been wide acceptance of our program because of De Paul's superior reputation in the community for many years," Miss Leland says. "DVR can also claim at least five years' experience in the alcoholic rehabilitation field, especially in the area of research."

Undoubtedly, the most impressive project of the rehabilitation program is the Sertoma Workshop, named after an international men's club which has been a sponsor of De Paul since 1961.

Located on spacious grounds separate from the hospital, the modern work center offers woodworking, light manufacturing, arts and crafts, and other production facilities for the recovering alcoholic. It also serves as a day care center for late chronics who cannot compete in a normal work environment.

The chores performed in the workshop are far from "make-work." Print-

ing and manufacturing contracts, for example, are bid for and obtained from numerous companies in the metropolitan Milwaukee area. Plaques and other handiwork made in arts and crafts are sold in the hospital gift shop as well as in the community.

According to A. Bela Maroti, Founder and Executive Director of De Paul, an important function of the workshop is to build up work tolerance so that the problem drinker can perform adequately in an 8-hour work day.

"Some patients from industry receive a 30-day period of work adjustment before they are authorized to return to their jobs," Maroti says. "Ordinarily, however, vocational evaluation is conducted concurrently with the treatment."

Maroti explains that some patients not referred from industry are absorbed by companies after the workshop experience because "their training here is not pencil-and-paper testing. It is on-the-job experience where they are punching a time clock."

Except for a couple of small engines, equipment in the workshop was purchased through DVR funds. "However, if we meet our $100,000 gross production quota this year," Maroti says, "we might be able to buy a few pieces."

What about success? "When dealing with alcoholism," Maroti says, "it must be remembered that it is a progressive disease, much like cancer. We have to talk in terms of arresting it, depending on the degrees of severity."

According to Maroti, alcoholism can be broken down into the following categories:

1. *Early phase* alcoholic, whose profile characteristics include employment and marriage with dependents. Most often, the alcoholic has no psychiatric problems. There are enough common denominators in this type of case for a 75 to 80 percent recovery rate.

2. The *young* alcoholic under 25 years old, generally with severe adjustment problems. He must be separated in counselling sessions from middle-age or middle-class patients. Different techniques must be used to reach him. According to Maroti, if he is told that he would feel better if he were productive, he might tell you, "I want to be free and do my own thing." Maroti adds, "You have to build a positive relationship on values that are important to him. There is no real measurement of success, although it is known to be less than in the adult industrial alcoholic population."

3. The alcoholic with *major psychiatric problems*, such as sex deviation or schizophrenia. Maroti is not referring here to causative relationships associated with alcohol, but to patients with mental illnesses (although in some cases alcoholism is a contributing factor). In this category there is a minimum success record of not more than 5 percent.

4. The *late-chronic* alcoholic who usually has no job or family and is supported by welfare. He has no serious degree of brain damage although he does have some form of character deterioration. Usually he continues to drink until he passes into the next category.

5. *Brain-damaged late-chronic* alcoholic who could be characterized as psychologically void and child-like.

Maroti says, "In the last two categories, success is measured by the patient's acceptance of constructive dependency without hostility. Some of these patients are cared for in 7 area halfway houses and are brought into the center by shuttle buses. They are involved in limited work activity, such as arts and crafts. It is structured recreation to keep them from falling into social isolation."

Maroti emphasizes that the late-chronic alcoholic is most often confined for life. "Some are 50 years old but their physiological age is 85." Some have perked up and shown that they can be productive and aggressive again after treatment, but their number is infinitesimal, he adds.

Fortunately, according to Maroti, not many problem drinkers cross the line to fall into the categories of late-chronic alcoholics. He also says there is one alcoholic for approximately every 16 persons who ever consumes alcohol or who can now be characterized as a social drinker.

A report from the National Institute of Alcohol and Alcoholism states that it takes from 10 to 20 years for a person to become addicted to alcohol. Other experts, however, report a shorter timeframe—about five years.

Warning signs in early stages of alcoholism include drinking to relieve tension or depression. Often during this phase the alcoholic begins to gulp or sneak drinks before attending a party where drinks will be served. During a severe drinking bout, he may experience blackouts or a loss of memory. Extreme feelings of guilt may follow these periods.

The second phase is marked by a progression of the disease. The alcoholic can no longer conceal his symptoms and the family becomes aware of the problem. Often the alcoholic at this stage will invent elaborate rationales and engage his psychological defense mechanisms as a buffer against criticism. As the disease progresses, the alcoholic becomes more withdrawn. Nutrition is neglected and the alcoholic's diet is replaced to a large extent by alcohol.

In the final stage, the alcoholic rarely experiences periods of sobriety. At this point, the alcoholic may literally drink himself to death.

Considering that the alcoholic's lifespan is 12 years shorter than that of the average non-alcoholic, and cirrhosis of the liver a frequent side effect, the DVR-DePaul Rehabilitation Program appears as a timely and crucial response to a killer disease—a disease that does not have to kill.

Early detection can make the difference. It is the difference between the old days of darkness and the new and beautiful days of light. IN

Ms. Reynolds is our correspondent covering SRS Region V.

Each year the President and Congress try to meet the July 1 deadline for new appropriations. They miss. Here's why and what happens next.

The way your money is controlled under a

Continuing Resolution

ARTHUR SPINDLER. What happens to human service programs when the normal flow of Federal money is interrupted? When Congress fails to pass HEW's—or any Government agency's —annual appropriations bill, or if the President vetoes it when it does get passed, how can the Government continue to operate?

There is, of course, the Constitutional requirement that "No money shall be drawn from the Treasury, but in consequence of appropriation made by law." If a mechanism does exist allowing continued funding of Federal programs during periods of non-appropriation or Presidential veto, what effect is there on assistance programs, planning, research?

Federal dollars are indispensable to most social service projects. In 1970, for example, more than half of the $143 million expended on such programs came from the Federal Government. Appropriations and trust funds are the two principal sources of Federal funding; they are the wellspring of these dollars.

But for the past few decades, and for increasingly lengthy periods during the past few years, the supply of appropriated funds has been flowing unevenly, diminishing dramatically during the early weeks, and more recently even during the early *months* of each new fiscal year. This phenomenon is the result of the failure of the budgetary process to produce enacted appropriation laws for Federal agencies by July 1—the beginning of the Federal fiscal year.

When July 1 rolls around and a Federal agency's appropriation bill has not been enacted (which is the case, for example, with HEW this year and in past years, as well), Congress does the following: to comply with the Constitution and still assure the orderly continuation of Federal activities, it passes and forwards to the President a "joint resolution" providing continuing, *interim* appropriations for those Federal agencies whose annual appropriations are not yet passed. The mechanism under which a given agency then operates is called a *continuing resolution*. Without it, in the absence of an annual appropriation, no payment, for whatever purpose to whatever recipient, could legally be made on and after the magic date of July 1.

But then what happens? How long does an agency whose annual appropriation has not been passed by Congress have to proceed under the interim law? Can it fund new programs, supply larger sums of money to existing ones, or make new and bigger commitments?

The length of the hiatus between July 1, and the date of enactment of an appropriation law has varied from year to year ranging from several weeks to months.

This fiscal year (1973), for example, appropriations for the U.S. Departments of Labor, Health, Education, and Welfare, and related agencies were not approved as of July 1, 1972. A Joint Resolution (Public Law 92-334) for continuing the appropriation of HEW and other agencies was passed on that date, with the provision that, "Appropriations and funds made available and authority granted pursuant to this joint resolution shall remain available until (a) enactment into law of an appropriation for any project or activity provided for in this joint resolution, or (b) enactment of the applicable Appropriation Act by both Houses without any provision for such project or activity, or (c) August 18, 1972, whichever first occurs."

On August 16, the President vetoed the bill. Two days later, both Houses of Congress approved, and the President signed into law, an amendment to Public Law 92-334 (the Joint Resolution), extending the authorization from August

18 to September 30, 1972. On September 29, Congress again amended the date to October 14, 1972. On October 26, another Joint Resolution continued this condition after the President vetoed the revised HEW appropriation bill and returned it to the Congress for reconsideration. In this instance, the date of authorization was pushed forward from October 14, 1972, to February 28, 1973.

The consistency with which joint resolutions have been introduced and approved by Congress and the President in current times suggests the inevitability of this procedure into the foreseeable future. Until changes are made in the budgetary process itself, or in a commitment to the July 1 deadline by Congress, the President, and the Executive Branch, the procedure is likely to continue.

Joint resolutions typically authorize spending of "such sums as may be necessary for continuing projects or activities (*not otherwise specifically provided for in the joint resolution*) which were conducted in the [previous] fiscal year and for which appropriations, funds, or other authority would be available in the regular Appropriation Acts [which have not yet been approved]". The rate of spending is limited to the lower of the current rate or to the rate provided for in the agency's budget estimate.

In instances where Congress *has* taken some action on the budget, the Resolution provides, "Whenever the amount which would be made available on the authority which would be granted under this Act listed in this subsection as passed by the House is different from that which would be available or granted under such Act as passed by the Senate, *the pertinent project or activity shall be continued under the lesser amount or the more restrictive authority.*"

As further clarifying guidance to the agencies, the Resolution states, "Whenever an Act listed in this subsection has been passed by only one House, or where an item is included in only one version of an Act as passed by both Houses, the pertinent project or activity shall be continued under the appropriation, fund, or authority granted by the one House, but at a rate for operations not exceeding the current rate or the rate permitted by the action of the one House, *whichever is lower.*"

The Resolution also provides that appropriations and funds shall *remain* available until enactment of the regular appropriation act or until the prescribed terminal date set by the resolutions, whichever occurs first.

The resolutions caution agencies that funds granted under them shall not be used "to initiate or resume any project or activity which was not conducted during the [preceding] fiscal year." The new nutrition program for the aged, for example, authorized at $100 million for FY 73, has had to be postponed under the present Resolution.

The resolutions quite clearly express the intent of the Congress that Federal programs be carried on during the period of the resolution at the lowest possible cost. In the words of the Director of the Office of Management and Budget, they must "not frustrate potential Congressional action on the regular appropriations that might provide a lesser amount."

Special budgetary controls over many HEW human service programs, for example, have been devised each year expressly to meet these expedient conditions.

When the continuing resolution period is expected to be brief and passage of the appropriation act imminent (*e.g.*, in several weeks or a month), these controls are not usually elaborate and their effects in holding program spending to arbitrary, low levels are minimal. Interim allotment ceilings were, and are, issued at one-twelfth the preceding fiscal year rate for continuation of programs and activities, to be replaced with regular quarterly allotments authorized by the appropriation act.

When, however, the interim period is expected to be protracted (three months or longer), elaborate controls are implemented to fit the fiscal requirements of the different types of programs and activities.

Allotments for formula grant programs are limited for the first quarter of the fiscal year to an amount no greater than one-fourth of the total authorized under the Resolution—that is, to the previous-year level, or to the amount approved by either House, or, if approved by both Houses, the lesser amount. Such programs as child welfare services, grants to States for vocational rehabilitation services, State grants for developmental disabilities, comprehensive health planning grants to States, and State grants for crippled children's services are governed by this structure.

For project grants and contracts, agencies are not permitted to obligate in any given month more than one-twelfth of the amount available under the resolution for each program and activity. Within this restriction, awards of new projects and grants are held to a minimum.

The first quarterly funds available to Federal agencies for direct operations, such as money for salaries and administrative expenses, are limited to one-fourth of the total amount available under the resolution. The so-called open-ended Federal/State programs (such as maintenance assistance, medical assistance (Medicaid), State and local training, and administration) funded under the Grants to States For Public Assistance are subject to the resolution. But their level of spending is not discretionary, since they cannot be manipulated by normal Federal control processes. The Social Security Act, as amended, commits the Federal Government to reimburse State and local governments for amounts spent for the specified programs; authorized matching formulas are applied. However, funds allocated under revenue sharing to State and local governments for social services and other programs under the State and Local Fiscal Assistance Act of 1972, or those from Social Security Trust Funds, are

Public Law 92-571
92nd Congress, H. J. Res. 1331
October 26, 1972

Joint Resolution

Making further continuing appropriations for the fiscal year 1973, and for other purposes.

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That clause (c) of section 102 of the joint resolution of July 1, 1972 (Public Law 92-334), as amended, is hereby further amended (a) by striking out "October 14, 1972" and inserting in lieu thereof "February 28, 1973" and (b) by adding the following new subsection and sections, after further amending clause (c) of section 102 by striking "or the sine die adjournment of the second session of the Ninety-second Congress:":

Continuing appropriations, 1973.
Ante, pp. 404, 533, 746.

Subsection 101 "(e) Such amounts as may be necessary for continuing activities for special benefits for disabled coal miners but at an annual rate for operations not to exceed $1,526,500,000.

"SEC. 108. Notwithstanding any other provision of this joint resolution, and section 10 of Public Law 91-672 and section 655(c) of the Foreign Assistance Act of 1961, as amended, obligations may be incurred hereunder for the activities hereinafter specified and shall, in addition to other funds available for such purposes, not exceed the annual rates specified herein during the period beginning October 15, 1972, and ending February 28, 1973:

84 Stat. 2055.
22 USC 2412.
Ante, p. 29.

86 STAT. 1204

86 STAT. 1205

"TITLE I—FOREIGN ASSISTANCE ACT ACTIVITIES

"FUNDS APPROPRIATED TO THE PRESIDENT

"ECONOMIC ASSISTANCE

Worldwide, technical assistance	$155,000,000
Alliance for Progress, technical assistance	77,500,000
International organizations and programs	105,000,000
Programs relating to population growth	100,000,000
American schools and hospitals abroad	25,500,000
American schools and hospitals abroad (special foreign currency program)	None
Indus Basin Development Fund, grants	10,000,000
Indus Basin Development Fund, loans	12,000,000
Contingency fund	25,000,000
International narcotics control	None
Refugee relief assistance (Bangladesh)	100,000,000
Alliance for Progress, development loans	150,000,000
Development loans	250,000,000
Administrative expenses:	
AID	50,000,000
State	4,221,000
Subtotal, economic assistance	1,064,221,000

"MILITARY ASSISTANCE

Military assistance	550,000,000
Regional naval training	2,500,000

"SECURITY SUPPORTING ASSISTANCE

Security supporting assistance	600,000,000

"OVERSEAS PRIVATE INVESTMENT CORPORATION

Overseas Private Investment Corporation, reserves	12,500,000

"INTER-AMERICAN FOUNDATION

Inter-American Foundation (limitation on obligations)	(5,000,000)
Total, title I, new budget (obligational) authority, Foreign Assistance Act Activities	2,220,821,000

92D CONGRESS
2D SESSION

H. J. RES. 1331

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 16, 1972

Ordered to be printed with the amendments of the Senate numbered

JOINT RESOLUTION

Making further continuing appropriations for the fiscal year 1973, and for other purposes.

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That clause (c) of section 102 of the joint resolution of July 1, 1972 (Public Law 92-334), as amended, is hereby further amended (a) by striking out "October 14, 1972" and inserting in lieu thereof "February 28, 1973" and (b) by adding the following new (1) ~~section:~~ *subsection and sections:*

(2) *Subsection 101 "(e). Such amounts as may be necessary for continuing activities for special benefits for disabled coal miners but at an annual rate for operations not to exceed $1,526,500,000.*

not subject to these restrictions noted above.

The effects of these delays in the appropriation process are pervasive. They also generally disrupt the orderly planning and administration of public human service programs. Under these conditions, as the first day of the new fiscal year draws near and annual appropriations have not been approved, all affected Federal agencies must set in motion procedures to initiate budgetary controls, revise budget forecasts, and take other measures to determine, *first*, interim spending ceilings, assuming passage of a Joint Resolution authorizing continuing appropriations; *second*, to prepare and implement contingency plans and set new targets for the ensuing year to accommodate the delays in new project starts and planned expansions in other program activity; and *third*, to prepare and transmit revised instructions, formulas, and guidelines to State and local governments and other grantees and contractors.

Some benefits and advantages *do* accrue from the delays. Each day, week, or month of delay in approving a multibillion-dollar appropriation (particularly when funding for new or expanded Federal programs and projects is requested) brings about reduced or postponed spending or forced savings (advantageous as a budget-reducing technique). The chances for reductions, postponements, or savings increase as the duration of the delay grows. Moreover, the delay does buy time for Congress and the President to consider, debate, or work out compromises on complex, costly, and controversial programs and issues. It relieves the pressures imposed on them by a precise and demanding July 1 deadline.

Nevertheless, in contrast to these benefits and advantages, the delay caused by late appropriations has a debilitating effect on agency program and financial planning. Program leadership is forced to observe a period of uncertainty about current plans and future direc-

tions, as substantive and funding decisions for the immediate period remain unresolved.

It is during this same period that (early in the fiscal year) administrators and program directors, already in awkward, potentially vulnerable positions, are requested to submit budget justifications for the *next* fiscal year. They cannot help but be uneasy.

These officials realize that their budget decisions can be disputed and weakened

when current year appropriations are passed. Moreover, program content and funding levels may differ from the preliminary predictions they must make.

Delayed funding has a mixed impact upon State and local governments, institutions, agencies, and other providers of services. These are the potential contractors or grantees for special-purpose projects and grants beginning in the new fiscal year. These prospective contractors and grantees, having developed plans and budgets, must revise them and postpone initial start-up actions in hiring staff, procuring materials and equipment, and making other commitments which obligate project or grant funds.

Contractors and grantees already implementing a previously approved project or grant are not affected adversely, if the time lapse between July 1 and passage of the appropriation act authorizing continuation funds is relatively short. However, the effects may be felt later in the year as weeks of delay become months. These contractors and grantees may, at first, experience little or no change in the amounts they receive from their Federal sponsor, assuming they request continuation funds at a fairly level spending rate.

For those contractors and grantees seeking a substantially larger dollar amount, some adjustment downward in next year's planned spending rate may have to be made. This is especially true if overall program limits imposed during the continuation period make such adjustments necessary.

To illustrate, most projects or grants are multi-year operations. That is, they will exist for three, four, or five years. The first year is typically a start-up period for planning, initial staffing, and operations. Financial needs are proportionately a smaller share of total costs. The second, third, and fourth years of a five-year project or grant are implementation years. Costs during this phase are usually significantly greater than in the first year. The fifth year of a project is generally devoted to evaluation, summarization, report writing, and close-out activities. Costs are less during this last year than in preceding years.

Should a project or grant of this type be in its first year of operation with continuation funds for the second year requested, Federal program reviewers have no alternative during the continuing resolution period but to seek to reduce the previously planned authorization below the requested level.

Formula grant recipients (usually State and local governments) are also affected. They are especially affected when substantial increases in Federal program appropriation requests are in the offing and the recipient government agencies have drawn up plans for expansion based on expectations of an increase in Federal funds.

Generally, though, in programs which do not expect large year-by-year increases, the first month or quarter allotments will approximate amounts previously made. In such cases, the effects upon State and local government programs will be minimal. However, they must take into account and adjust to the inflationary rise in service and administrative costs. The same Federal allotment amount as authorized the previous year must be discounted by 6 to 12 percent, depending upon the nature of the costs. Health and medical costs, for example, have been rising at approximately twice the rate of other costs.

If allotment reductions are made because of a continuing resolution, governmental units either temporarily postpone hiring new employees as replacements for those who leave, or try to cope with caseloads with a smaller number of personnel and dollars.

Fortunately, to minimize the harsher effects on continuing grants, projects, and service operations, the pattern of Federal projects and grants administration (at least in SRS) is such that more than half are approved during the last quarter of the fiscal year (in April, May, or June). Late appropriations, coupled with late-in-the-year policy decisions on training, research, and demonstrations, as well as on other special program strategies have produced later authorizations for projects and grants.

To accommodate the financial needs of schools and colleges receiving Federal training contracts and grants, some Federal agencies, including SRS, have a policy of forward financing in the fourth quarter of the year to make funds available at the beginning of the regular school year.

The chronic inability of the Congress and the Executive Branch to meet the July 1 fiscal year deadline in the Federal budgetary process is the subject of intensive discussion by responsible Government leaders. Viable alternatives for change are being considered. Meanwhile, Federal, State and local officials, and other prospective and present grantees and contractors, need to be alert to the conditions and qualifications in Federal funding which must be met because of the continuing resolution.

At the Federal level, contingency budget planning must be drawn up to minimize the effects of the delays in funding. At State and local government levels, officials should seek temporary alternate funding to avoid reductions in service programs caused by reduced Federal allocations. They should evaluate their programs to eliminate waste and inefficiency. Studies to achieve the most favorable cost-effectiveness and benefit-cost relationships should be made.

Others who are prospective or present Federal contractors and grantees should understand the constraints imposed upon Federal officials under a continuing resolution. They must exercise reasonable conservatism in holding project or grant cost estimates to the lowest possible levels consistent with the effective performance of their agreements with the Government. HN

Mr. Spindler, retired SRS Program Planning Director, is a social systems consultant.

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For more information concerning the content of these films write Media Division, Office of Public Affairs, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C. 20201.

Self-help groups

can also work for prisoner rehabilitation

RICHARD E. LAWRENCE and GEORGE W. KRIEGER.The prisons of America are filled with men and women convicted of a variety of crimes against persons, property, and society. We generally speak of them as the "criminal" class, a large indistinct group upon whom society places certain judgments—not unlike the way we speak of "the poor," "the minorities," and "youth."

But with convicted criminals as with any group, we can only make progress by moving as quickly as possible from the hazy generality to the sharply defined specific. We would like all criminals, once they have served their time in prison, to return to—and make peace with—society. Many of them will, if we help them learn how. It is in everyone's interest that they do learn.

Although the need is evident, such professionals still have not moved into rehabilitation in maximum security institutions. The two foremost reasons are (1) a lack of funds to hire the professionals, and (2) the absence of available rehabilitation personnel to assume positions in correctional institutions.

The need persists amidst the growing concern over the relationship between increasing crime rates and recidivism among previously institutionalized law violators. Clearly society must do something besides just incarcerating convicted men and women. But what can be done without more dollars and more persons trained in the social and behavioral sciences. A partial answer may be found in the resources already available right inside institutions.

The literature abounds with references to self-help groups in settings other than corrections. Alcoholics Anonymous, for example, has been in existence for years with reported results equalling or exceeding the results of any other form of treatment for those suffering from alcoholism. Recovery, Inc., works with ex-mental patients and those with mental problems who have not been hospitalized. And the Fortune Society has been serving offenders outside correctional institutions with significant success.

There is, however, little known about the application of the same self-help principles inside a maximum security institution. However, we do have one such model for the delivery of treatment services in a maximum security prison. This is how it came about.

In the summer of 1970, several representatives of the Maryland Department of Corrections approached us with a challenging request: What can you do to help us alter the therapeutic climate in Maryland prisons and promote treatment and rehabilitation?

Several programs were designed for possible responses, of which the self-help group concept was one. We were asked to implement that model in the Maryland Correctional Institution (MCI) of Hagerstown.

Men inside this walled prison are called "inmates." They are viewed—and view themselves—as a different social class, substantially lower than the social class of the staff. Information to substantiate this hypothesis about social status was gathered over many months of contact and discussions with staff and inmates throughout MCI.

Numerous questions of a program nature were raised after we obtained approval to proceed with the self-help model. Actually the establishment of self-help groups in correctional settings is not much different from establishing them in other settings. We had to deal with the anticipated questions concerning the organization of the groups, selection of participants, staff involvement, and the scheduling of meetings and activities. These had to be settled before the groups could get started.

The responsibility for making these early decisions was given to the psychological counselors, doctoral students in rehabilitation counseling. They resolved the basic questions of time, group membership, and setting and set initial goals. In addition, the length, frequency of meetings, and duration of the group were tentatively agreed upon. We also consider what would be the nature of the group: should it be psychotherapeutic, socially oriented, or educational? Should members be screened with respect to psychopathology or areas of concern, or should groups be heterogeneous and voluntary?

Another very crucial issue related specifically to self-help groups but not necessarily to correctional settings: the relationship of the counselor to the group. Was the counselor to be a group leader, an observer, a consultant, an advocate, or a trainer? In some instances, a counselor observed self-help group meetings; in others, he consulted with designated member-leaders.

The counselors confronted several issues peculiar to self-help groups in a maximum security correctional institution or in institutions with characteristics in common with correctional settings. For example, institutional administra-

tors were skeptical of therapeutic activities and, consequently, hesitated to permit them. Moreover, security-minded officials were concerned about "what goes on" behind closed doors when offenders meet alone. Some regular staff members reacted unfavorably to such new group practices as the "hot seat," role-playing, communication skills activities, and other "non-traditional" forms of interaction. Lastly, psychological counselors had to be prepared to allay the concerns of non-group inmates about their peers in the group, as well as the concerns of the group participants themselves who had past experiences with therapeutic activities or agents.

At the outset, it was evident that the role of the psychological counselor would differ because of the setting. In part, role distinctions were necessary because of some underlying assumptions of the usual and desirable goals associated with counseling. Psychological counseling is usually thought of as a "freeing experience" for the client, giving him greater independence and responsibility. In addition, counseling frequently increases the client's ability to cope with his environment and to strengthen his personal and social adjustment.

Are such goals possible or even desirable in a correctional setting? Well, such goals might be beneficial for some clients in prison, but they were probably inappropriate in a maximum security prison such as MCI. Counseling can be beneficial to counselees in prison, but there ought to be a change in the role of the counselor and an alteration of goals.

The titles of "resource-consultant" and "trainer" clarified the new roles of the psychological counselor. He was to organize and structure the group. Next he explained the self-help group model and some of its possible outcomes.

This new counselor would be available to the group or to individuals within the group whenever necessary. He would also assist in the resolution of group conflicts over issues and of personality clashes as well. His function was to ensure that the therapeutic group would be organized and run smoothly.

As a resource person, the counselor would interact with group members to increase their self-awareness, help them focus on the nature of the process, and give feedback based upon his observations. On other occasions, the counselor becomes a trainer-instructor who can demonstrate interpersonal and communication skills to the group. If conflict should arise between persons within the group and persons outside the group, he

would intervene to increase acceptance of the group's function. Finally, the counselor helps disband the group and assists its members to bridge the gap over to non-group inmates when the group has ended its therapeutic sessions.

There are many advantages to the resource-consultant and trainer roles for the psychological counselor in a maximum security correctional institution:

First, it is a time saver, since the counselor doesn't have to meet with each group at every session. Rather, he has trained others to serve as "leader" role and his expertise is needed only occasionally.

Second, there is less conflict within the group over this "outsider" and the authority he has in the group. His presence is infrequent; instead, the group requests his presence when they need him.

Third, movement is generated more quickly in the absence of an outside leader. Honesty and openness were qualities evident from the very outset of the group sessions. Without an official authority figure, there was no need to "test him out and size him up."

Fourth, involvement and committment are maximized. There is no way to wait for the "professional to do it for me." It becomes the job of each individual group member to assume the responsibility for what he does or doesn't do within the group.

This model for the delivery of services is a unique one for the psychological counselor in a prison. As resource-consultant and trainer, he is *not* the center or focal point of the group. He functions, rather, to prepare others to do the traditional work of the counselor and, in turn, he assumes the role of resource-consultant, available when needed. Such a role is a challenging one for the counselor, regardless of setting, and frankly may not fit well at the outset.

Selection of members for self-help groups can take place in many ways. Usually the motivation will come from the inmates. In our case, some leaders emerged naturally. These leaders, in conjunction with the counselor, then determined a selection scheme. Volunteers were solicited and then placed in a training group. This training group concentrated on the purpose of the self-help group: namely, setting goals for individual members and promoting counseling skills.

The primary purpose of the group was clear to all its members. The secondary goal was to focus on interpersonal dynamics, such as training within the insti-

tution, vocational planning, self-control, and keeping in touch with the community. Techniques were then developed to help reach these goals.

Individual members were helped to establish personal goals. For example, one member needed to curb his aggressive tendencies; another needed to learn to take the initiative more often; one person made plans to return to a former job; another decided he needed retraining for a new career. Some members wanted help but were not able to develop specific goals. This was tolerated until goals could be set.

Counseling skills were promoted. (An introductory text in counseling, *The Helping Interview* by Benjamin (1969), was used.) Common problems that frequently arise in counseling were explored. Role-playing was found to be helpful; an encounter between an officer and an inmate was played out.

The "Hot Seat" technique was discussed and then used by the counselors and group members. It proved to be helpful in enabling the group to know other members and promote self-awareness. The group members alternated in questioning one member. Initially, a member volunteered to be on the "hot seat." Hopefully, this target person would gain insight into his behavior and perceive alternative paths to follow. Questions were direct and often pugnacious. The "target" person was asked how he had contributed to his own incarceration and what he planned to do about it, or to explain his behavior in a given situation. The purpose was to open up honest communication and to help the "target" person set goals for himself.

A given session was often viewed as hostile, anxiety-producing, and demanding by members. An underlying atmosphere of support and concern developed and became most necessary. Results were beneficial; the confrontations opened the way to counseling progress.

In the maximum security setting at MCI, all participants responded positively to the group and indicated it did provide them with a chance to express and explore their problems. They apparently learned much about the other men and found they shared many problems in common. They also felt they were able to plan their time better in the institution and to plan for their release. The sharing of plans and giving of suggestions was extremely helpful.

Early evidence indicates that the group members who were released have remained in the community and are satisfied with the progress and adjustment they have made. Recidivism has been non-existent for a six-month period for group members released from prison.

The model of the self-help group in a prison seems to hold great promise as a means of delivering treatment services to inmates. It gives the men a real stake in their own treatment. It provides the counselor, as resource-consultant-trainer, a chance to work with many more clients than he could under a one-to-one model. Early self-report evidence is promising, but more research is necessary.

The major weakness in the present data is the influence of motivation. All group participants were volunteers and highly motivated to become involved and better themselves. It is not at all clear if the favorable self-reports and other data would be as positive if the group were formed through assignments rather than through volunteering. Men highly motivated toward rehabilitation may do as well upon release *without* the self-help group experience.

There are other unanswered questions: Are the characteristics of group therapy present in the self-help group? Does the group make faster progress when one or more of the members have had formal group experience? Should the leader have special training? Indeed, should an official leader be designated at all? How should the prison administration be involved? Does the presence of officers or other prison officials enhance or inhibit group progress?

Although self-help groups have been beneficial in other settings and with persons other than prison inmates, this is a first step to modifying, implementing, and researching such groups in maximum security prisons. At the outset, we had many reservations about the efficacy of self-help groups in prisons primarily because of depersonalization and the punishment (rather than treatment) orientation of most maximum security prisons. However, the MCI experience was gratifying. Follow-up is strongly suggested, with greater emphasis on a research design that will permit conclusions to be drawn and modifications to be recommended. Still, even at this early stage in its development in prisons, the self-help group appears to hold a potential for treatment and rehabilitation of incarcerated public offenders. **BN**

Dr. Lawrence is Director and Dr. Krieger is Associate Director of Rehabilitation Counselor Education at the University of Maryland.

needs assessment

Key to better planning.
Basis for effective management.
Guide to resource utilization.

The "single door" concept and more Regional responsibility take the mystery out of grants.

The SRS system for Project Grants

ALBERT ROTUNDO. We can only make progress by trying new things, new approaches, new answers. But trying takes money—which Federal agencies have been dispensing through discretionary grants.

SRS is no exception. In 1972 our discretionary grant program distributed $212 million to public and private organizations, predominantly American but including a few foreign organizations with special expertise.

The discretionary grant is different from the usual formula grant which provides basic support for social and rehabilitation services on the State and local level. The discretionary grant does not offer basic support for any project, but rather it provides seed monies for new research and experimentation and the development of better skills which can later be translated into on-going programs. These grants are therefore what are commonly known as "project period grants": they supply funds for a specific project over a limited amount of time, usually on a matching-cost basis.

There are three general types of discretionary (or project) grants available from SRS: the research and demonstration grant, the manpower and training grant, and the service grant.

Research and demonstration grants provide funds for actual demonstrations of innovative social and rehabilitation service which can be developed into widespread programs after the termination of the initial project. However, these are not pure research grants, because they directly provide social rehabilitation services to clients in the course of their duration.

During the past five years, for instance, SRS has funded 21 demonstration projects designed to show how life for the aged could be vastly improved by better nutrition; under these projects better meals were delivered to thousands of elderly people across the Nation. Congress studied these experiments and expanded them in the Older Americans Act of 1972, by providing for a new national program of nutrition for the aging.

Manpower and training grants supply funds for the training of professionals and other skilled personnel in the delivery of social and rehabilitation services. The purpose of this part of the program is to remedy the lack of sufficiently trained personnel who must staff the social and rehabilitation programs of the future.

In 1972, SRS awarded over 1,000 training grants to establish courses and stipends in such fields as, for example, rehabilitation counseling, occupational therapy, speech pathology, and social work and gerontology.

Service grants provide start-up funds for the development of experimental programs in the area of social and rehabilitation services. Among these projects have been the following: model programs and area-wide demonstrations for the aging, youth development and delinquency prevention, and rehabilitation expansion and facility improvement programs. Many of the projects funded thus far under this part of the discretionary grant program have subsequently been integrated into on-going Federal-State programs. The Government hopes that all of the future service grant programs will be similarly integrated.

Discretionary grants are available to any State or local agencies and organizations, to educational institutions of higher learning, and to non-profit agencies and organizations. The cost-sharing varies with each grant; the grantee may be asked to supply anywhere from 5 percent to 75 percent of the cost. Funding is for a specified time—from one to three years for research and service grants, and from one to seven years for training grants. During 1972, some 1,500 organi-

zations received these discretionary grants for a total of more than 3,200 different projects.

Some of the projects funded by SRS discretionary grants will give an indication of the scope and variety of the pro-

grams we sponsor. They will also demonstrate how this seed money has ultimately benefited countless others beyond the original demonstration group.

1. A grant of $12,300 was awarded to the Community Service Society in New York City to develop a program to enlist elderly retired people in volunteer social work. The project was called SERVE (Serve and Enrich Retirement by Volunteer Experience). It was based on the premise that there are two groups of people who could benefit immeasurably by interaction: elderly persons, often lonely and with little to do to occupy their time, and the vast number of deprived people, both children and adults, who could benefit from personal contact with retired people.

A group of 642 elderly and retired volunteers was recruited for 27 service agencies and the project proved a success. There was a 70 percent retention rate among elderly volunteers. Both groups benefited: the recipients of the volunteer service showed remarkable and unexpected improvement, and the morale of the elderly people increased dramatically as they again felt themselves to be useful and occupied. As a result of this project, New York State instituted a Statewide SERVE program and the Federal R.S.V.P. (Retired Senior Volunteer Program) was modeled on the original SERVE project.

2. The National Association of the Deaf in Silver Spring, Maryland, was awarded $74,200 to develop a training program for people who would work as interpreters for the deaf.

The Vocational Rehabilitation Act of 1965 had called for the provision of interpreters for the deaf, but there had been no funding. For many years there was an acute shortage of these interpreters, severely hampering the communication of deaf persons with other people and imparing the quality of service they received.

This project thus attempted to implement the Rehabilitation Act by stimulating the recruitment, training, and certification of interpreters for the deaf. Extensive research was carried out on all aspects of interpreting, including site visits to many service agencies for the deaf. From this research the NAD developed a complete training ciruculum, as well as a code of ethics and standards of performance for interpreters. The course was widely distributed to colleges and agencies throughout the country. Since then there has been a marked increase in the number of courses now offered and the number of newly certified interpreters.

The Association then listed these interpreters in a national registry and in a series of separate directories for each HEW region. At the start of the project, the Association had a listing of only 300 interpreters, but today the directory lists over 1,100. The project has also helped 29 States establish local chapters of interpreters for the deaf which work closely with State VR agencies. These chapters recruit, train, and professionalize interpreters for the deaf.

3. A grant of $43,100 was awarded to the Alaska Department of Health and Welfare in Juneau to conduct a two-year social services experiment for 14,000 people who live in a remote and impoverished area of the State.

This territory comprises 60,000 square miles of tundra and mountains which lie along the Bering seacoast. The people are almost all Eskimos and Athapaskan Indians. They suffer from the severe climate, a desperate lack of communications, and few opportunities for making a living.

The project grant aided the State Department of Health and Welfare to do a careful check on the people already on its rolls, to discover what other people were in need of services, and to obtain an accurate picture of living conditions and needs in 50 remote villages of the area.

The project selected 19 native leaders from the area and trained them to work in their own villages as human services aides. Seventeen members of the group were Eskimos and two were Indians; there were three women in the group. They were provided with nine months of training, including both classroom study and supervised field work.

In the field, these new aides were able to compile histories and chronicles of these villages for the first time. They took numerous photographs to document their findings about living conditions. But, more importantly, they used their knowledge of the area and its people to deliver useful and needed services. They discovered serious health problems and made referrals of clients for treatment; they provided care for mistreated and neglected children; they helped with financial problems, includ-

ing the establishment of eligibility for public assistance; and they translated and wrote letters for the villagers, most of whom knew little or no English.

The demonstration shed much light on

the facts about these hitherto unknown people, most of whom were uneducated, unemployed, and isolated. And the project showed that the villagers were able to communicate with and trust the local aide more than caseworkers or other people from the outside.

The project itself delivered a great amount of service in the two-year peiod, but it has had on-going implications. The

Department is now more aware of the needs of the people in the villages and the type of services they require. Today it feels it is delivering better social services, particularly through the efforts of native aides who are now used in the regular service.

Discretionary grants have had a long and distinguished history in the Federal Government. But in 1967, when SRS was established, 30 different grant programs in the social and rehabilitation area were put under this one jurisdiction. During the first two years there was an understandable amount of overlapping authority in the programs. This necessitated a tremendous amount of paperwork for any organization seeking a grant: a grantee was forced to approach eight different offices to process a grant application and there were 49 different forms to be filled out.

But in 1969 SRS launched an aggressive program to overhaul and simplify the grant process. This whole project was in line with President Nixon's expressed desire of "rationalizing, coordinating, and decentralizing the system through which government provides important social and economic services."

The overhaul process in SRS's discretionary grant program sought to implement the "one door" concept so that there would be a single source and a single application for a grant. The overhaul has now been completed with extremely gratifying results. All project grants programs were first consolidated in one central office in Washington, our Division of Project Grants Administration. Then, as part of the decentralization process, a Grants Management Officer was appointed in each of the 10 SRS regions to assist the Regional Commissioners with their newly given authority to approve grant applications and monitor them at the regional level. Finally the paper work was greatly simplified. Instead of the former 49 forms, there are now only three forms used in the grant program—a uniform application form, an award notice, and a report of expenditures.

During 1972 over 70 percent of the discretionary grants awarded were approved and administered at the regional level. This means there is better technical assistance for the grantee because the grants management officer is closer to the actual scene. However, the regional office staff are also a creative force in the field: they often suggest projects to institutions, they frequently solicit additional funds from other local agencies for grant projects; and they are able to coordinate various grant programs of organizations in their area.

This streamlining of the grant process has provided important benefits for both the grantor and the grantee. The processing time for a grant application has been reduced by six weeks; and the grantee now has a more simplified way of applying for a grant and is not obliged to commit as much time and money to the application process.

The entire reorganization of the grant process was accomplished at no extra expenditure for the Federal Government. On the contrary, during the first 18 months of the new system the Government estimated it had saved over $300,000 in costs and six man-years in time.

The SRS discretionary grant program has an application kit which may be obtained directly from the SRS Division of Projects Grant Administration (330 C Street, S.W., Washington, D.C. 20201) or from any one of the local Grants Management Officers in the 10 SRS Regional Offices.

Those organizations who obtain the kit will notice that the application requires all the usual assurances contained in most grant applications—a valuable project, adequate staff, management capability, estimate of expenses, cost sharing proposal, etc. But there is one other important objective which must be accomplished in this SRS program: all the grants must include a utilization strategy. In other words, the organization proposing a project must be able to demonstrate how the results of the project could be used to improve the delivery of social and rehabilitation services. In all the grant projects described in this

article there was a strong utilization element—the demonstration not only benefitted the immediate demonstration group, but the results could be applied to other situations as well.

SRS continues to accept discretionary grant applications. The central office in Washington or any Regional Office is able to supply further information about this important program which seeks to improve the delivery of social and rehabilitation services. IN

Mr. Rotundo is Director of the Division of Project Grants Administration in SRS headquarters.

Montana's workable evaluation model.

Six steps to measure Change

HELEN MARTZ and JOHN TRAUTH. How do you get from theory to practice? Is it really possible to "evaluate" results and come up with "measurements" of success or failure?

We believe the answer to these questions is uniformly "Yes." That doesn't mean, however, that the answer is easy. To get to an affirmative answer requires some careful planning and follow-through on a step-by-step basis.

In addition to clear answers to simple questions, evaluation can perform other, more sophisticated, less black-and-white functions, depending on the interest and intentions of the administrator. Usually, evaluation is called upon to provide measurements of "cause" (what is happening, what is going on in some project or program) and "effect" (what is the result of all that activity).

By taking the evaluation process as far as he can, the administrator provides himself with a strong aid for modifying and improving his program. As an example of what we mean by this, we will sketch out the evaluation process—going from theory to practice—as it is occurring in an SRS health care demonstration project.

Now in its third year of operation, the "Helena Comprehealth Plan" is a project funded under Section 1115 of the Social Security Act. The primary purpose of this exemplary Montana project is to test the feasibility of a prepaid health care program for the "medically needy." The Montana State Department of Social and Rehabilitation Services has been considering extending Medicaid (Title XIX) coverage to this group—the "medically needy"—but it must have a lot more data before making its recommendations to the State legislature.

Currently the project has approximately 700 enrollees, representing some 330 families. For purposes of evaluation, there is an experimental group of enrollees in Comprehealth and two control groups. Within the experimental group are three "sub-populations": persons eligible for Medicaid under the law, persons who are "medically needy" but not covered by Medicaid, and a third group—also not covered by Medicaid—who participate in the plan through modest premium contributions. All, however, share a few common characteristics: they live in Lewis and Clark County (the city of Helena is both the county seat and the State capital) and their income is within 133 percent of present public assistance requirements.

The project is funded by SRS through a Section 1115 grant; however, the insurance carrier is private, Blue Cross of Montana. The purpose of the project is to demonstrate whether a prepaid, privately underwritten, comprehensive health care program can provide a reasonable alternative to the present system of paying for medical care under Title XIX. In this respect, the project—particularly its prepayment element—is a kind of forerunner of what an HMO (Health Maintenance Organization) might be.

A secondary objective of this project is to demonstrate the value of using paraprofessionals in the delivery of health-related supportive services and in gaining greater utilization of health and medical resources among the poor and near-poor. The paraprofessionals in the Helena Comprehealth Plan are called "Case Aides." They are citizens of the county. Many of them, in fact, were formerly on welfare themselves.

The project is highly interesting and—when its initial three-year funding period is completed in September 1973—more will be heard of it, to be sure. For now, however, we prefer to concentrate on the evaluation component in Comprehealth, since this component will contribute a good deal to our final conclusions next fall.

Evaluation planning in the Comprehealth project has followed in general a six-step course:

First, project goals and objectives were set out and carefully refined.

Second, the hypotheses to be tested in the project were defined for the benefit of both the participants and the sponsors.

Third, the criteria to be measured were also given proper definition.

Fourth, specifications were set out for what constituted the "success levels" of this project.

Fifth, the design of the evaluation research was further refined.

Sixth, information drawn from the evaluation process was fed back to the operations side of the project.

These six statements are broad-brush. Here is what they mean close up in the Helena project.

A serious failing of many project applications is the fuzziness of their statements of goals and objectives. A project with a goal of "improving the quality of life of the welfare recipient" can't be

faulted for its intentions, but such nobility is impossible to measure. At the outset, therefore, the project director, the governmental representatives (Federal, State, regional), and the evaluators must hammer out specific, *measurable* goals and objectives. These will be subject to evaluation activities and we will all learn whether or not the project is getting anywhere in the course of time.

During this first step, therefore, some goals and objectives fit together and are combined on paper; additional ones are developed; conflicts between goals are identified and resolved; and some goals and objectives are discarded as simply beyond the scope of the project. By getting this down on paper we avoid the foggy "quality of life" and bring into sharp relief such specific, measurable objectives as "lower incidence of disease," "reduced frequency of emergency hospital care," or "better self-perception" (itself a borderline piece of business but nevertheless subject to quantitative measurement through interviews and surveys). This refinement of goals and objectives makes it possible for the Helena project personnel to collect relevant data and feel secure that the data can be handled in some manageable rational data system.

Once the project goals and objectives have been thus refined, the next step is to define the hypotheses upon which the project is based. The hypotheses are major statements of cause and effect, the central stuff of evaluation.

In a way, you could say that the "demonstration hypotheses" are the assumptions upon which the whole project was based. Comprehealth, for example, is testing the assumption (the hypothesis) that it is economically and operationally feasible to provide comprehensive medical services to welfare recipients through a private, prepaid insurance plan.

Another hypothesis in Comprehealth involves the use of the Case Aides. Here the cause-and-effect relationships are even clearer. The two underlying hypotheses for this aspect of the project are (1) that the inclusion of health-related supportive services and health care education in the medical delivery system increases the ability and willingness of project recipients to utilize health care services more effectively, and (2) that the use of former welfare recipients as paraprofessionals, after training and under appropriate supervision, is a feasible way of providing health-related supportive services to the disadvantaged.

At this point we are coming closer to reality, but there are still some steps to go. For example, what is meant by "economically and operationally feasible"? or "feasible and effective"? or "ability and willingness"? This is where we must pin down the project criteria.

In step three there are two types of data which can be used to test demonstration hypotheses: quantitative ("hard") data and qualitative ("soft") data. The first is made of specific numerical measurements, while the second measures attitudes, feelings, perceptions. Both "hard" and "soft" data should be used to test out hypotheses. For example, let us return to that (1) hypothesis involving the Case Aides: that the inclusion of health-related supportive services and health care education in the medical delivery system increases the ability and willingness of project recipients to utilize health care services effectively.

This would constitute the *hard data*: more frequent and appropriate medical care utilization by project recipients than an equivalent Medicaid sample; fewer missed doctor appointments by project recipients compared to Medicaid recipients; better access to medical services for project recipients as measured by requests for transportation and child care services when recipients are going to the doctor or hospital.

This would constitute the *soft data*: more favorable attitudes toward medical care and doctors on the part of project recipients; favorable recipient attitudes toward health-related supportive services provided; more recipient knowledge of medical care and appropriate use of preventive health care practices.

It should be clear from the above that there are certain data collection systems to be needed. They will yield real numbers, from which some evaluation measurements can be drawn. But how will we know the project is any good or not? Obviously the numbers must come up to or pass some kind of line. We have called this a "success level" and the fourth step in this process is to put down on paper what the specifications of success levels ought to be.

One can be overwhelmed by the power of numbers and, in such a case, lose hold on an otherwise good project. In Comprehealth we believe a reasonable beginning was made when the base for comparison was established to be the number of claims per enrollee per month. Next, we agreed that *marginal success* would be a 10 percent increase over Medicaid recipients. (We must bear in mind that we wanted health services used more, meaning more claims to the carrier.) *Very successful* was determined to be over 20 percent but under 50 percent. Over 50 percent was considered to be *too successful*; that rate meant that the increased costs would be so great as to challenge the basic "feasibility" hypothesis.

This process must be repeated for every criterion: how many and what kind of transportation services? what are "favorable attitudes"? and, finally, which ones and how many of the success criteria must be achieved in order to establish the success of the hypothesis itself? Undoubtedly the success criteria will have to be modified as more experience is gained with Comprehealth, as would be the case with every new project being evaluated in this manner. But modification isn't a sign of weakness in the original formulations but a sign of strength in the on-going project.

If the foregoing steps are followed reasonably well, then the fifth step—refinement of the evaluation research

design—would naturally follow. The project itself is changing, in part because of the presence of an evaluation design; clearly that design should be subject to necessary changes as well.

With the other parts of the evaluation design in place, it is now time to keep track of them, refine them, and add certain specific timetables for activities. With timetables—however crude—we can begin to carry out the evaluation work plan: the things we have to do in the evaluation process and when we have to do them.

In Comprehealth we decided that progress should be measured and preliminary comparisons made at six-month intervals. At this point we would gather in the measurements of all qualitative and quantitative criteria—the "hard" and "soft" data. We would do this, by the way, for the three groups involved in this project: the experimental group (with its three sub-populations) and the two control groups (non-participating Medicaid eligibles and a group of non-participating non-recipients). Thus far in the project, this six-month cycle has proved to be workable.

Once it is apparent that the project and the evaluation process are both underway and running along in tandem, it is necessary to install the appropriate feedback mechanisms. We don't have to wait until a project is terminated to discover whether or not it has been successful. With a proper feedback mechanism, we can see periodically how things are going, monitoring not only the project but the evaluation process itself, in order to make any necessary "course corrections."

For example, in one of our feedback surveys of Comprehealth we learned that recipients felt "their health had improved significantly since joining the program." They also felt they were getting better health care from providers and that provider attitudes toward them were better as well. They had a better understanding of what preventive health care is all about. In addition, they were quite receptive to the cost-sharing idea (through nominal premiums). The utilization rate was found to be "heavy." However, recipients also felt that there was "insufficient child care services."

Looking closely at this child care problem, for example, we gained the "hard" data showing that Case Aides were actually working overtime on matters relating to child care. Earlier, about 20 percent of the parents indicated that child care is a problem when attempting to gain medical care, but only 5 percent reported that project staff provided child care services. In contrast, only 10 percent of the Medicaid control parents cited child care as a problem, yet 32 percent said they had received this service. The project director had been asked to correct this situation. The result was nearly an impact of the system at this point. However, another Case Aide was brought on the staff just for child care service and the matter has since subsided as a major concern of Comprehealth recipients. (Awareness of the preventive medical service is also a factor. For example, 40 percent of the Comprehealth parents felt their children needed to see a doctor, while only 28 percent of Medicaid control parents felt that way.)

This description of the evaluation process as it applies within the Helena Comprehealth Plan is intended mainly to show that evaluation is the movement from the general to the specific. The methodology is based on the specifics. With the gathering in of the specific information, the evaluator can come full circle again and make some informed observations on the general hypotheses of the project. The process tells you where you have been and where you probably ought to be going, invaluable information for people in the field of social services. **IN**

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Here are some practical considerations for helping the handicapped get around.

Removing Barriers from the pathways of the Handicapped

H. GORDON GREEN. In apparent indifference to the plight of America's handicapped, architectural design thoughtlessly and relentlessly places habitation and transportation barriers before tens of thousands of people. Perhaps this neglect is a carry-over from the days when deformed or disabled persons were hidden away, out of sight.

The precise number of disabled persons in the United States is unknown, but some approximations help tell the story. In the mid-1960's an estimated 250,000 Americans used wheelchairs; 200,000 people used heavy leg braces; 140,000 used artificial limbs; and 5,000,000 had more-or-less disabling heart disease. If the 16,500,000 Americans over 65 years old are added, and the many who are limited in sight or hearing are also included, a very sizable number of citizens is restricted in mobility.

In fact, approximately one out of every seven individuals in the U.S. has some degree of permanent disability. One expert has even suggested that by 1980, for every able-bodied person there will be a physically disabled, chronically ill, or over-65 person. And this does not take into account the temporarily disabled.

Increasingly during this century, disabled persons have been restricted in movement, both within and between buildings. The design of the man-made environment proceeds with callous indifference. Such barriers include the *presence* of such things as:

- curbs in the paths of wheelchairs
- doors too narrow for wheelchairs or too heavy to open for someone using crutches
- flights of steps too steep for the infirm, and
- hazards (such as lampposts) in the paths of the blind.

Barriers also include the *absence* of other items such as:

- bathroom handrails for the disabled
- parking spaces wide enough for a paraplegic driver to unfold his wheelchair
- visual signals for the hard of hearing, and
- raised-letter signs for the blind.

The problems of architectural barriers were first brought forcefully to public attention in 1957, when Hugo Deffner was cited by President Eisenhower as the "Handicapped American of the Year." To receive this award, Mr. Deffner had to be carried onto the stage of the Federal auditorium by two Marines because his wheelchair could not make the steps. This dramatic demonstration of insensitive design, as well as Mr. Deffner's continued personal efforts, led directly to official action to improve accessibility of facilities to handicapped persons.

In 1958, a year following Mr. Deffner's award, a meeting of the Advisory Council to the President's Committee on Employment of the Handicapped was held at the White House. This and subsequent meetings provided important stimuli to the development of ground rules leading to mandatory accessibility standards in the construction of new Federal buildings.

Using information gathered by researchers (primarily from the University of Illinois), the influential American Standards Association adopted a general program to reduce the occurrence of architectural barriers in other types of construction. The standards were presented in detail at the 1961 meeting of the National Society for Crippled Children and Adults (the Easter Seal Society), a co-sponsor of the project. Some of the standards included the following:

- utilization of ramps in addition to—or instead of—steps, with gradients to rise vertically not more than 1 foot for each 12 feet of horizontal distance
- doorways at least 32 inches wide, to accommodate larger wheelchairs as well as crutch users
- steps, when used, to have rounded nosing with minimum overhang low ris-

ers (not more than 7 inches) and handrails (32 inches high, extending 18 inches beyond the top and bottom stairs), and

- lavatory facilities to include at least one toilet stall 3 feet wide and 5 feet long, equipped with grab bars and hand rails, to accommodate wheelchair users.

Other standards included ground-level entrance doors, automatic doors, raised numbers and letters on doors and elevators, audible danger signals, low placements of telephones, non-slip flooring, and more.

The specifications touched upon general principles, site development, and building construction. Specific standards were presented for almost all phases of life within buildings, hopefully to serve as a guide not only to architects and builders but also to governmental authorities concerned with public facilities.

The Federal Government responded. HEW granted funds for a national inventory of architectural barriers. The Public Health Service provided money to implement the standards in communities. The General Services Administration applied the ASA standards to its own 4,800 Federal buildings and to many of its leased buildings as well. Finally, the National Commission on Architectural Barriers to Rehabilitation of the Handicapped, after a series of seminars, hearings, and conferences, made the following recommendations:

- Federal legislation should require all new public buildings and facilities to be designed to accommodate the elderly and handicapped if *any* Federal funds are used in their construction
- Executive Orders should make mandatory accessibility standards in new construction
- State legislation should provide for State and local building accessibility for the handicapped
- building codes for public-use buildings should be revised
- government agencies should be assigned responsibility for administration and research in this field, and
- public education and information activities concerning architectural barriers should be expanded.

State and local communities also took action. Upon the suggestions of local citizens and organized groups of the handicapped, more than half of the States passed laws regarding accessibility of the disabled to public or tax-supported buildings. Several other States issued Governors' executive orders. States such as Hawaii and New York held conferences on architectural barriers. Community inventories of facilities were compiled by groups such as local architectural standards committees and Junior Leagues. More than 40 guides to accessible buildings were issued. Local legislation resulted in the levelling of street curbs and the installation of guide rails and surfaces.

The problems, though, were still great. A mail survey by the National League of Cities showed that local governments had made only limited progress in changing codes and policies because they relied instead on State legislation. Public attitude surveys showed that 64 percent of Americans had given the subject of architectural barriers little thought. Even architects generally were unfamiliar with the ASA-Easter Seal standards. There was also concern that barrier-prohibiting legislation would greatly increase the cost of buildings. Primary recognition of the barrier problem and the impetus for change came from those who were directly affected.

Provision for special features to make buildings fully accessible were indeed found to increase costs, though often less than 1 percent of total construction costs. And the point was repeatedly made that, if the barriers are dropped, "disabled" people would *not* necessarily be "handicapped" in the activities of daily living.

The publicity generated by these activities not only increased the general awareness about obstacles for perhaps 70 percent of the population, but it also prompted many private building owners to better understand the benefits of total accessibility.

Private buildings are not affected by the legislation, but they are affected by local building codes. Owners of stores, offices, restaurants, and hotels are becoming increasingly attentive to the needs of disabled persons. Awareness is spurring their committment to action. Hotel chains (Holiday Inns, Howard Johnson Corporation, Ramada Inns, and TraveLodge Corporation, among others) have included special rooms for the handicapped. These hotels have wheelchair accommodations in bathrooms, extra-wide doors, hand rails, lowered electric switches, tilted mirrors, and trapeze hooks over the beds. (Unfortunately, they also have somewhat higher rates.)

Access for disabled persons to public buildings (both tax-supported and pri-

vately owned) is only a part of the solution to the overall problem. Even if the buildings themselves are usable, the disabled person must be able to get there. Private transportation, with expensive hand controls in automobiles, is the answer for only a limited number of the disabled. The blind, the hard-of-hearing, the aged, and the poor are automatically excluded; many others are unable to utilize hand controls. Though Hertz and Avis now have rental cars available with hand controls in the largest cities at no additional fee, the number of handicapped who have drivers' licenses is not large.

In a few cities (Phoenix, Denver, Milwaukee, Chicago, and Indianapolis) Yellow Cab and Handi-Cab provide special taxis for the handicapped. They are equipped with wheelchair ramps or lifts, anchors, and other special devices.

But in general, modes of transportation are not designed to accommodate the disabled. Few find boarding a bus easy. The steps from curbs to streetcar or bus entrances are so high that they present a barrier not only to the aged and handicapped but also to small children. Subway stairs and turnstiles are a hindrance; the portable boarding ladders used by many airlines are a strong barrier to those with orthopedic, cardiac, or geriatric handicaps.

The National Commission found that transportation is the most serious problem encountered by the disabled. But progress is being made, primarily through continuing action by individuals and groups. An outstanding example is the Bay Area Rapid Transit (BART) system now serving the San Francisco Bay area. Built as a combination of subway, surface, and elevated rail systems, BART is the world's most modern public transportation facility.

The original BART bond issue in 1962 made no specific provision for facilities for the handicapped. A campaign enlisting the disabled, the aged, and the general public was led by Herold L. Willson, himself a wheelchair user, with the support of the Easter Seal Societies of Alameda and Contra Costa Counties. In 1968, the California State Legislature passed a bill requiring adherence to the ASA standards. It was not aimed specifically at BART, rather it covered *all* public buildings and facilities. Further efforts led to the provision of additional funds through a sales tax.

With continued effort, the BART system,, when fully completed, will have virtually 100 percent access in all 34 stations. Features include wide parking spaces, elevators with telephones, Braille indicators on elevator door facings, special toilet facilities controlled by an attendant, extended handrails on all

stairs, audible station announcements in the cars, lowered telephones and drinking fountains, car loading in a position level with the platform (adjusting automatically with the weight of the load), and room for three or four wheelchairs in each car.

Now Mr. Willson is putting his considerable and persuasive talents to work again to convince the Federal Government to require new buses to be equipped for loading and carrying disabled persons. At this time such buses are custom-made and very expensive.

Airplane travel has still further to go in providing services to the handicapped. The American Rehabilitation Foundation, under an SRS grant, has a "wheelchairmanship" program which includes training sessions and films for airline passenger service personnel. Both United Airlines and Pan American World Airways have special training programs for employees ranging from airport porters to stewardesses. Early boarding and special seating can usually be arranged, but there is no room for a wheelchair. Wheelchairs must travel in the freight compartment, increasing the risk of damage.

Many airline commissaries can prepare special diets, if advance notice is given. Some of the larger airlines use a "jet way" for boarding, eliminating the necessity for being carried up steps. There is no provision, however, for wheelchair users in the passenger area, and the narrow aisles are virtually impossible to navigate safely on crutches. Thus, the experienced disabled traveler will dehydrate himself by drinking nothing after bedtime prior to a flight and by voiding before boarding.

At the present time, there are no standards or specifications which the transportation industry must meet because Federal, State, or local accessibility requirements are lacking.

The life-saving and prolonging powers of medical science are adding increasing numbers to the ranks of the disabled and chronically ill, those who in another age would have perished. This trend will increase demands in both public and private sectors for freedom from barriers. The climate for barrier-free design has never been better.

Our society is giving more and more attention to providing for disadvantaged minorities. An awareness of both the needs and the specific actions required to meet those needs is increasing. Subjective understanding and sensitivity provide support for objective specifications and standards so that changes in design and construction may occur. It is reasonable to anticipate that with continuing effort to bring the problems to the attention of the building community and the general public we may yet create an environment which is *used* and *enjoyed* by *all* people. **IN**

Dr. Green is an assistant professor at the University of Arkansas Medical Center in Little Rock.

CAREER OPPORTUNITIES

Social Work Supervision

LOCAL WELFARE DIRECTOR II. MSW and 1 year of experience in social work. Additional experience may substitute for MSW on a year for year basis. $9,470—$15,315. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

FIELD CONSULTANT, CHILD AND FAMILY SERVICES. Professional supervisory and consultation work in public welfare. Master's degree and 5 years of experience or a Bachelor's degree and 8 years of experience. $10,975—$13,596. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

SUPERVISOR, ASSISTANCE PAYMENTS. Master's degree in social science and 3 years of experience or a Bachelor's degree and 6 years of experience. $9,531—$11,639. Write: Dept of Personnel, State House Annex, Concord, N.H. 03301.

ASST. CHIEF, MEDICAL SOCIAL SERVICE. Master's degree in social work or a related field with 3 years of experience in social work or 1 year in medical social work or medical care administration. $10,495—$13,022. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

PLANNING-FUNDING SPECIALIST. To conceptualize, coordinate, and write new or expanded programs contingent upon funding sources. Master's degree in Social Work plus 5 years of experience. $11,000 to $15,000 dependent upon qualifications. Write: Director, Juvenile Welfare Board, 3455 1st Ave., So., St. Petersburg, Fla. 33711.

RESEARCH-EVALUATION SPECIALIST. To compile, analyze, and interpret statistical data. Bachelor's degree and at least one year of graduate training in Social Work and 5 years of experience in statistical work and/or research. $11,000—$15,000 dependent upon qualifications. Write: Director, Juvenile Welfare Board, 3455 1st Ave., So., St. Petersburg, Fla. 33711.

TRAINING SPECIALIST. Master's degree in Social Work plus 5 years of experience. $11,000—$15,000 dependent upon qualifications. Write: Director, Juvenile Welfare Board, 3455 1st Ave., So., St. Petersburg Fla. 33711.

Rehabilitation

REHABILITATION COUNSELOR. In facility setting, primarily for mentally retarded. Master's degree preferred in rehab. counseling or related field, or bachelor's degree. Experience helpful but not required. $8,000 (B.A.); $9,200 (M.A.). Write: Sup'r, N. Cent. Rehab. Ctr., 746 14th Av. N., Fort Dodge, Iowa 50501.

ASST. WORKSHOP DIRECTOR (Rehabilitation). Bachelor's degree preferred. $8,500 depending on qualifications. Write: Director, Randolph County Sheltered Workshop, P.O. Box 151, Red Bud, Ill. 62278.

VOCATIONAL EVALUATOR II. Master's degree in vocational rehabilitation, vocational evaluation, or Bachelor's degree and 2 years of experience in vocational evaluation, rehabilitation, tests and measurements or other related field. $9,408—$11,708. Write: Vocational Evaluation Supervisor, Vocational Evaluation Unit, 1620 E. Polk At., Phoenix, Ariz. 85006.

PSYCHOLOGIST. Performs work-oriented psychological appraisals for a multidisability vocational evaluation and work adjustment program. Master's degree in psychology or rehabilitation, must be able to qualify for certification as Psychological Associate in Texas. Previous rehabilitation experience and bilingual (Spanish) preferred but not required. $12,000. Write: Program Administrator, Harlingen Vocational Evaluation Center, 300 Camelia, Industrial Airpark, Harlingen, Tex. 78550.

VOCATIONAL EVALUATOR. Bachelor's degree in Industrial Arts Education, Sociology or Psychology. Master's degree with testing/counseling experience preferred. $10,000. Write: Vocational Evaluation Unit, 3987 University Drive, Fairfax, Va. 22030.

ALCOHOLISM PLANNERS. (6 positions). Bachelor's degree with some graduate training, and planing or community organization experience. $10,600—$12,900. Write: Robert Threlkeld, Bureau of Rehabilitation, 32 Winthrop Street, Augusta, Maine 04330.

ASSISTANT SUPERINTENDENT (Correctional Diagnostic Treatment Facility). Bachelor's degree with major work in psychology, sociology, penology or a related social science. Four years of experience, including 1 year of administrative. Master's degree may be substituted for 1 year of experience. $12,948. Write: Superintendent, Correctional Diagnostic Treatment Facility, P.O. Box B, St. Albans, Vt. 05478.

Nutrition

SUPERVISING DIETITIANS Minimum qualifications for Dietitians plus additional 2 years of experience, or a master's degree and completion of an approved dietetic internship may be substituted for 1 year of experience. $9,814—$11,894. Write: State Dept. of Civ. Serv., State Off. Bldg. Campus, Albany, N.Y. 12226.

DIETITIANS. Bachelor's degree in dietetics or related field, or in home economics with major in nutrition, and 1 year of experience in hospital or therapeutic dietetic work, or completion of approved postgraduate hospital dietetic internship, or master's degree in dietetics or nutrition. $8,648—$10,104. Write: State Dept. of Civ. Serv., State Off. Bldg. Campus, Albany, N.Y. 12226.

DIETITIAN TRAINEES Bachelor's degree with major in dietetics or related field, or home economics. $8,169. Write: State Dept. of Civ. Serv., State Off. Bldg. Campus, Albany, N.Y. 12226.

DIETICIAN I. Bachelor's degree with major work in dietetics, institutional administration, or hotel administration. $8,163—$10,432. Write: Pa. State Civil Service Commission, Bureau of Recruitment, Rm. G-53, So. Office Bldg., Harrisburg, Pa. 17120.

PUBLIC HEALTH NUTRITIONIST TRAINEE. Bachelor's degree with major course work in foods and nutrition. $8,163—$10,432. Write: Pa. State Civil Service Commission, Bureau of Recruitment, Rm. G-53, So. Office Bldg., Harrisburg, Pa. 17120.

NUTRITION SPECIALIST. To direct a state-wide program in nutrition for the elderly. Bachelor's degree in food/nutrition plus Master's or MPH in nutrition. Completion of a dietetic internship or its equivalent. $15,787. Write: Coordinator, Division of Administration on Aging, Dept. of Mental Health and Mental Retardation, 1105 Ohio Dept. Bldg., Columbus, Ohio 43215.

Adult and Aging Programs

FIELD CONSULTANT ADULT SERVICES. Professional, Supervisory and consultation work in public welfare. Master's degree

with 4 years of experience or 2 years in supervision, or a Bachelor's degree and 7 years of experience. $10,495—$13,022. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

FIELD REPRESENTATIVE ON AGING. To develop and carry out community programs in State Office on Aging. Bachelor's degree in public administration, psychology, personnel management, or related field, and 2 years of experience in public or private personnel, public health, or related field. $593—$842. Write: Merit System Council, 1910 W. 7th St., Little Rock Ark 72202.

SPECIALIST IN AGING I. To collect and communicate information about status of senior citizens, to train and supervise staff. Master's degree or bachelor's and 1-2 years of experience in related field, or equivalent experience and training. $9,612. Write: Dir., Sr. Central, Mayor's Office for Sr. Citizens, 223 N. Michigan Ave., Chicago, Ill. 60601.

SPECIALIST IN AGING II. To administer field program. Master's degree and 2-3 years of experience or bachelor's degree and 3-5 years of experience. $11,700. Write: Dir., Sr. Central, Mayor's Office for Sr. Citizens, 223 N. Michigan Ave., Chicago, Ill. 60601.

CLINICAL PSYCHOLOGIST. Doctor's degree in psychology. $1,062—$1,497. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

Mental Health

PSYCHOLOGY DIRECTOR. Doctor's degree in psychology and 4 years of postdoctoral experience in clinical psychology. $1,226—$1,729. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahasse, Fla. 32304.

PSYCHIATRIST I. Medical degree, completion of approved internship, and 1 year of approved psychiatric residency. $1,777—$2,443. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PSYCHOLOGIST II. Master's degree in psychology and 1 year of experience. $787—$1,088. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PSYCHIATRIST II. Minimum requirements for Psychiatrist I, and 3 years of experience. $2,084—$2,667. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

CLINICAL PSYCHOLOGIST. Consultant to social service staff, administers and interprets psychological examination, participates in the monitoring and assessing of social service purchases under Title IV of the Social Security Act $10,980—$15,660. Write: Personnel Director, St. Louis County Welfare Dept., 422 West Third St., Duluth, Minn. 55806.

SENIOR PSYCHOLOGIST. To operate rural mental health clinic. Master's degree and 4 years of experience. $13,000 and negotiable. Write: Psychologist-Administrator, Southeastern Colo. Family Guidance Center, Otero County Court House, La Junta, Colo. 81050.

Health Services

EDITORIAL RESEARCH ASSOCIATE. To review literature and research in field of Maternal and Child Health and to report and evaluate MCH projects under study. Experience and education in health sciences, journalistic ability, and editorial experience in field of health. $17,000. Write: Helen M. Wallace, Md., U. of Calif., School of Public Health, 513 Earl Warren Hall, Berkely, Calif. 94720.

PUBLIC HEALTH EDUCATOR. To direct comprehensive health education program. Master's degree in public health education and 3 years of experience $995—$1,250. Appointment at a higher grade permitted if candidate's qualifications exceed the minimum. Write: Merit System, 4th Floor, Centennial Office Bldg., 658 Cedar St., St. Paul, Minn. 55155.

PUBLIC HEALTH NURSE TRAINEE. Graduation from an approved school of nursing $7,407—$9,454. Write: Pa. State Civil Service Commission, Bureau of Recruitment, Room G-53, So. Office Bldg., Harrisburg, Pa. 17120.

Manpower Services

RESEARCH AND STATISTICS SPECIALIST. Master's degree in social science or related field and 2 years of responsible research experience, including the planning and conduct of research activities. $13,728. Write: Coordinator, Div. of Admin. on Aging, Dept. of Mental Health & MR, Room 1105, Ohio Depts. Bldg., Columbus, Ohio 43215.

DIRECTOR OF RESEARCH AND EVALUATION. Master's degree in behavioral sciences, Ph.D. preferred. Experience in survey research and statistics, experience in evaluation of social action programs desirable. $16,000—$20,000. Write: Correctional Manpower Services Project, 203 North Wabash Ave., Suite 2210, Chicago, Ill. 60601.

SYSTEMS ANALYST. To develop and operate a system of information storage and retrieval. Master's degree and 4 or more years of experience. $15,000. Write: Director, Meyer Children's Rehabilitation Institute, (U of Neb.) 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR OF PLANNING, EVALUATION AND RESEARCH (Health Care). Master's, Doctorate or Medical degree preferred. 2 years of experience relating to health care systems. $14,000—$24,000. Write: Vanderbilt University Professional Recruitment, 110 Baker Building, 110-21st Ave., So., Nashville, Tenn. 37203.

MANPOWER PLANNING SPECIALIST. Master's degree in planning, business administration, industrial engineering or social sciences desirable. Ability to write well required. $15,000—$18,000. Write: Correctional Manpower Services Project, 203 North Wabash Ave., Suite 2210, Chicago, Ill. 60601.

EXECUTIVE DIRECTOR (Mental Retardation). Bachelor's degree with administrative or supervisory experience. Salary is negotiable. Write: Chairman of Board, LOMR, 2202 So. 11th St., Lincoln, Nebr. 68502.

ADMINISTRATIVE OFFICER. Bachelor's degree and 3 years of experience in personnel, budgeting, research, or administrative management. $10,500—$13,500 dependent upon qualifications. Write: Director, Juvenile Welfare Board, 3455 1st Ave., So., St. Petersburg, Fla. 33711.

INFORMATION - COMMUNICATION SPECIALIST. To plan, coordinate, and direct community and public relations activities concerning needs of and services for children and families. Bachelor's degree, preferably with a major in Journalism or English and 4 years experience. $10,500—$13,500. Write: Director, Juvenile Welfare Board, 3455 1st Ave., So., St. Petersburg, Fla. 33711.

Medical Services

PHARMACIST II. Degree in pharmacy, licensed to practice in Florida, and 2 years of experience. $929—$1,290. Write: Dept. of Admin. Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

NURSING DIRECTOR I. RN and 5 years of professional experience at supervisory or administrative level. $810—$1,122. Write: Dept. of Admin., Div. of Pers'l. and Retirement Carlton Bldg, Tallahassee, Fla. 32304.

PHYSICAL THERAPIST (FIELD). Graduation from an approved school of physical therapy and licensed to practice in Va. $8,400

—$10,992. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

Casework

CASEWORKER (PROTECTIVE SERVICES INTAKE). Intensive treatment of parents and children, MSW. No experience. $793. Write: Dir., Qutagamie Co. Dept. of Soc. Svc., Court House Annex. Appleton, Wis. 54991.

SOCIAL WORKER. MSW or related field (not rehabilitation counseling). $11,046 (GS-9). Write: Dir., Alcohol & Drug Off., Hq. Ft. Hamilton, Brooklyn, N.Y. 11252.

SOCIAL WORKER II. To work as Probation and Parole Agent or as Counselor in Correctional Institution, MSW. $878—$973 Start. Write: Supervisor of Recruitment, Div. of Corrections, Box 669, Madison, Wis. 53701.

MEDICAL SOCIAL WORKER—B. Master's degree and 2 years of experience. $9,168—$12,000. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

MEDICAL SOCIAL WORKER C. Master's degree and 3 years of experience. $10,032—$12,528. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

CASEWORKER I. Bachelor's degree and knowledge of principles and techniques of social case work. $508—$719. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

PUBLIC HEALTH SOCIAL WORKER. MSW and 2 years of experience including supervised social case work and clinical experience. Driver's license necessary. $11,929—$12,412 (Upstate) $12,129—$12,612 (Metropolitan Area). Write: Director, Public Health Social Work, New York State Dept. of Health, 845 Central Ave., Albany, N.Y. 12206.

CASEWORKER II. Bachelor's degree in sociology or related field 1 year of graduate study toward MSW or 1 year of experience in social work. $549—$779. Write: Merit System Council, 1910 W. 7th St., Little Rock. Ark. 72202.

SOCIAL WORKER II. Bachelor's degree and 1 year of experience. $9,023—$10,663. Write: Dept. of Civil Svc., Arnold Constable Bldg., Front & Montgomery Sts., Trenton, N.J. 08625.

MEDICAL SOCIAL WORKER—A Master's degree. $8,040—$8,784. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

SOCIAL WORKER. Bachelor's degree and 3 years of experience. 3 years as County Director (as certified by Commr. of Public Welfare) may be substituted for college. $593—$842. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

Mail your agency's classified listings to Editor, HUMAN NEEDS, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or nongovernmental listings accepted. There is no charge or fee of any kind for this service.

SOCIAL SERVICE WORKER III. Bachelor's degree and 3 years of experience or 1 year of graduate work and 1 year of experience. $8,748—$10,656. Write: State Personnel Commission, P.O. Box 6756, Phoenix, Ariz. 85005.

COUNSELOR, INTENSIVE TREATMENT UNIT. Master's degree; no experience required. $10,020. Write: Director, Outagamie County Dept. of Social Services, Court House Annex, Appleton, Wisc. 54911.

SOCIAL WORKER. To direct an Alcoholic Treatment Addiction Center, MSW. $10,600. Write: Employment Manager, Kings County Hospital Center, 451 Clarkson Ave., Bldg. D, Brooklyn, N.Y. 11203.

Faculty Appointments

PROGRAM SPECIALIST REHABILITATION OPERATIONS MANAGEMENT OR PRODUCTION. Plan, organize, and teach in training seminars for rehab personnel, may teach 1 undergraduate class. Some travel. Master's degree in Rehab. Management, Ind. Ed. or Ind. Engineering and 5 years of experience. Salary according to qualifications. Write: Project Dir., Region III Training Program for Facility Pers., Jull Hall, U. of Maryland, College Park, Md. 20742.

SPEECH PATHOLOGIST. Direct and coordinate speech pathology, language development, teaching and research program. Ph.D. Salary open and competitive. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha. Neb. 68131.

PROJECT DIRECTOR. To coordinate health manpower study, conduct surveys and collect data. Master's or Ph.D. preferred but not essential; familiarity with survey methods, health manpower data sources. $15,000, some room for negotiation. Write: Director, Health Systems Res. Div., Box 210, Med. Sci. Bldg., U. of Florida, Gainesville, Fla. 32601.

ASSISTANT DIRECTOR. To develop and implement projects, do research, direct graduate students, and teach as required in health systems. Ph.D. in operations research, engineering, business admin., or behavioral science with quantitative emphasis. Some experience in health systems analysis desirable. $18,000. Write: Dir., Health Systems Res. Div., Box 210, Med. Sci. Bldg., U. of Florida, Gainesville, Fla. 32601.

CORRECTIONS INSTRUCTOR. To teach undergraduate and graduate classes in corrections, probation and parole. Doctorate degree and 3 years of experience in a correctional agency. Salary is negotiable, depending on experience. Write: Director, Corrections Program, Chicago State U., 500 North Pulaski Rd. Chicago, Ill. 60624.

DIRECTOR SOCIAL WORK TRAINING. Direct and coordinate teaching and research programs in social work for children with handicaps. Ph.D. or D.S.W. with interest in developmental disabilities and experience in community organization. Salary open. Write: Director, Meyer Children's Rehabilitation Institute (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR, PHYSICAL THERAPY PROGRAM. Master's degree with certification in neurodevelopmental (Bobath) treatment, experience in children's programs. $12,000—$13,000. Write: Director, Meyer Children's Rehabilitation Institute (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR, OFFICE OF MANAGEMENT SERVICES. To direct a University based, multidisciplinary program for children with developmental disabilities. Ph.D. in academic areas related to program evaluation and systems technology and/or information processing with experience in programming and computer utilization. Salary open and dependent upon experience. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.) 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR OF SOCIAL SERVICES. MSW and 3 years of experience, 2 years working with the retarded. $12,732—$15,337. Write: Associate Administrator, Division of Mental Hygiene and Mental Retardation, P.O. Box 2460, Reno, Nev. 89595.

COORDINATOR FOR CONTINUING EDUCATION AND IN-SERVICE TRAINING. To provide the major staff resource for the Institute's in-service training and education programs, including technical assistance to community services. Master's degree and experience in developing continuing education programs. Salary dependent upon training and experience. Write: Director, Meyer Children's Rehabilitation Institute (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

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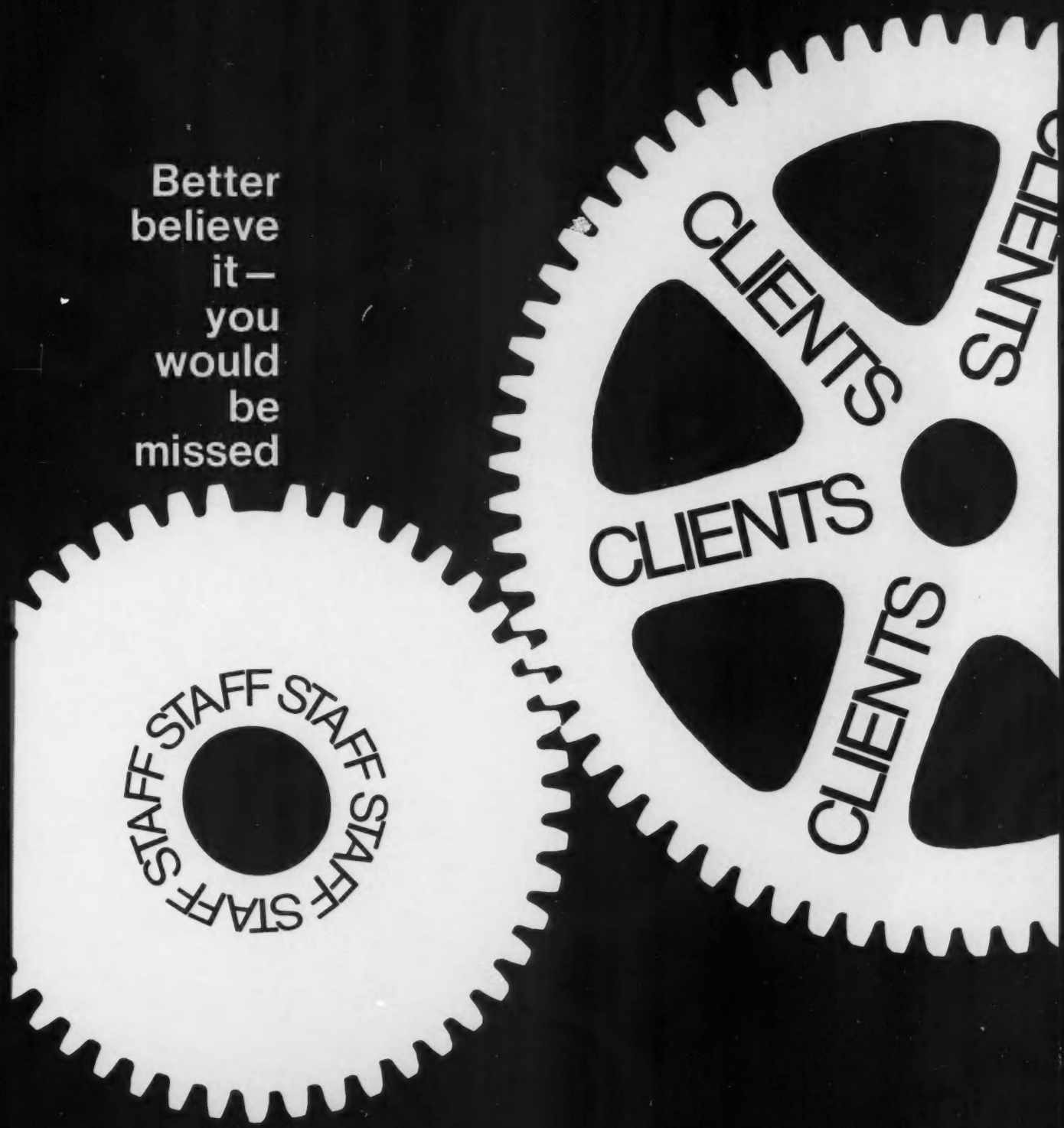

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